PROTOCOL CODE: GIAVCAP

<table>
<thead>
<tr>
<th>DOCTOR’S ORDERS</th>
<th>Ht cm</th>
<th>Wt kg</th>
<th>BSA m²</th>
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REMINDER: Please ensure drug allergies and previous bleomycin are documented on the Allergy & Alert Form.

DATE: [ ]

To be given: [ ]

Cycle(s) #: [ ]

Date of Previous Cycle:

- [ ] Delay treatment ______ week(s)
- [ ] CBC & diff, platelets day of treatment

May proceed with doses as written if within 96 hours ANC greater than or equal to 1.5 x 10⁹/L, Platelets greater than or equal to 75 x 10⁹/L, Creatinine Clearance greater than 50 mL/minute

Dose modification for:

- [ ] Hematology
- [ ] Age/ECOG
- [ ] Other Toxicity ________________

Proceed with treatment based on blood work from __________________________

CHEMOTHERAPY: [ ] Repeat in three weeks

capcitabine [ ] 1250 or [ ] 1000 mg/m² (select one) x BSA x ( _____ %) = _________mg PO bid with food x 14 days

(Round dose to nearest 150 mg)

RETURN APPOINTMENT ORDERS

- [ ] Return in three weeks for Doctor and Cycle _________
- [ ] Return in six weeks for Doctor and Cycle _____ & _____.
- [ ] Last Cycle. Return in ______ week(s)

CBC & diff, platelets, creatinine prior to each cycle

If clinically indicated:

- [ ] BUN
- [ ] Albumin
- [ ] Bilirubin
- [ ] Alk Phos
- [ ] GGT
- [ ] ALT
- [ ] CEA
- [ ] CA 19-9

- [ ] INR weekly
- [ ] INR prior to each cycle

- [ ] Other tests:

- [ ] Weekly Nursing Assessment

- [ ] Consults:

- [ ] See general orders sheet for additional requests.

DOCTOR’S SIGNATURE: [ ]

SIGNATURE: [ ]

UC: [ ]